Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALFREDO VAZQUEZ, DC
3100 TIMMONS LN STE 250
HOUSTON, TX 77027

Respondent Name

STANDARD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-0016-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER FAILED TO PROPERLY PAY THE CLAIM EVEN AFTER IT WAS SENT TO CARRIER FOR RECONSIDERATION. I HAVE LEFT SEVERAL MESSAGES FOR THE ADJUSTER AND DID NOT GET A CALL BACK."

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the Provider's submitted documentation. The documentation supports that the Provider was appointed as the Designated Doctor, and reimbursement should be made. Consequently, the Carrier is issuing reimbursement for the disputed services in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 07, 2010	99456-W6-RE and 99456-W7-RE	$750.00	$750.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041(a-h) provides general provisions for Designated Doctor (DD) Examinations and carrier responsibilities for payment of such services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 29, 2010
   - CTWL 218 – BASED ON ENTITLEMENT TO BENEFITS. NOT REIMBURSABLE BECAUSE THE WORKERS COMPENSATION CLAIM HAS BEEN DENIED BASED ON COMPENSABILITY, DISABILITY, OR A COMBINATION OF REASONS.
   - FEES W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.

   Explanation of benefits dated August 13, 2010
   - W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. Has the Designated Doctor (DD) Examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. The provider (DD) billed the amount of $500.00 for CPT code 99456-RE-W6 for an Extent of Injury (EXT) determination. The provider also billed $250.00 for CPT Code 99456-RE-W7 to determine whether the injury was a Direct Result of the work related incident (DIR).
2. Review of the submitted documentation finds that the Division ordered a DD examination to determine EXT as well as answer questions regarding DIR. The requestor was contacted on September 27, 2010 to determine payment status of the disputed issues and the services had not been reimbursed as indicated in the respondent's position statement.
3. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examinations is $500.00. Per 28 Texas Administrative Code §134.204(i)(2)(B) & (k), the reimbursement for the 2nd RTW/EMC examination is 50% of MAR which is $250.00. The combined MAR for the MMI/IR services rendered is $750.00.
4. Respondent denied services based on "CTWL 218 – BASED ON ENTITLEMENT TO BENEFITS. NOT REIMBURSABLE BECAUSE THE WORKERS COMPENSATION CLAIM HAS BEEN DENIED BASED ON COMPENSABILITY, DISABILITY, OR A COMBINATION OF REASONS."
   Texas Labor Code §408.0041 states in part (a)(3)(4):

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

   (3) the extent of the employee's compensable injury;

   (4) whether the injured employee's disability is a direct result of the work-related injury;

   Texas Labor Code §408.0041 states in (h)(1):

   (h) The insurance carrier shall pay for:

   (1) an examination required under Subsection (a) or (f).

   The requestor rendered the services ordered by the Division, and is therefore entitled to reimbursement as described above.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $750.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $750.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 07,2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.